

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement of \$8,789.84 for date of service 01/23/01.
- b. The request was not date stamped.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. HCFA 1450
  - c. EOB(s)
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60
  - b. HCFA 1450
  - c. EOB(s)
  - d. Peer Review dated 01/06/02
  - e. TWCC 62
  - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
- 3.. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 02/25/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 02/26/02. The Commission case file does not contain a 14 day response from the provider or the carrier. The file contains an unstamped request for medical dispute resolution packet from the provider and two responses from the carrier dated 01/29/02 and 02/08/02.
4. The Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: The requestor submitted no correspondence relating to the dispute. The notes on the Table of Disputed Services read, "Carrier denied per code 'M' and did not supply documentation of 'methodology' per 133.304 or pay at a 'fair and reasonable' rate."

2. Respondent: In the 02/08/02 response submitted by the carrier in an unsigned, undated letter, the carrier stated, "The injured worker slipped and fell while cleaning and fractured the right elbow...The claimant had surgery to the elbow and has had on-going medical treatment. A peer review was accomplished and the report was received on January 7, 2002....Peer Review dated January 6, 2002. The review states in part: 'Based upon the review of the medical records, the documentation does not support the need for a highly structured, goal oriented, individualized work hardening program as it relates to the injury date...In regards to the program itself, the documentation does not support this is a work hardening program...'."

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/23/01.
2. The provider billed \$11,412.31 for date of service, 01/23/01. The carrier paid \$2,236.00 for services billed for date of service, 01/23/01. The amount in dispute for the date of service is \$8,789.84.
3. The service was performed at an ambulatory outpatient setting. The provider unbundled charges according to Rule 133.1 (a) (E) (16) which states, "Unbundling—Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all of the treatments or services that were billed separately, or fragmented one treatment or service into its component parts and coding each component part as if it were a separate treatment or service."
4. The carrier denied charges by denial codes, "M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE." The carrier submitted a Notice of Medical Payment Dispute dated 02/14/01. The audit cites "Entitlement, Not Documented, Charge Unrelated to Compensable Injury, Not According to Treatment Guidelines, Unnecessary Medical" as "rationale for disputing entitlement to medical payment or denying the medical necessity." The Medical Review Division's decision is rendered based on the fair and reasonable denial code submitted to the provider prior to the date of this dispute being filed.

#### **V. RATIONALE**

Medical Review Division's rationale:

The Commission's case file does not include a copy of the operative report for services that were billed for date of service, 01/23/01, per Rule 133.1 (E) and Rule 133.307 (g) (3) (B) therefore, no reimbursement is recommended to the provider.

The above Findings and Decision are hereby issued this 14th day of May, 2002.

Donna M. Myers, B.S.  
Medical Dispute Resolution Officer  
Medical Review Division